STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SU	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLE	
		155586	B. WIN			12/21/2	.012
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ANTHONY BLVD		
LUTHER	AN LIFE VILLAGES	3			VAYNE, IN 46816		
(X4) ID		TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	'-	DATE
F0000							
			F00	00			
	This visit was for t	the Investigation of					
	Complaints IN001	20765 and					
	IN00120862.						
	Complaint IN0012	20765					
	Substantiated. Fe	deral/ state					
	deficiencies relate	ed to the allegations					
are cited at F 241, F250, and F353.							
	Complaint IN0012	20862					
	Substantiated. No	deficiencies related					
	to the allegations	are cited.					
	Survey dates: Ded	cember 18, 19, and					
	20, 2012						
	Facility number	: 000283					
	Provider number:	155586					
	AIM number:	100275020					
	Survey team:						
	Christine Fodrea,	RN					
	Census bed type:						
	SNF/NF: 129						
	Residential:	42					
	Total: 171						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/08/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:			00	COMPL	
		155586	A. BUI B. WIN	LDING		12/21/	
			P. WIN		ADDRESS, CITY, STATE, ZIP CODE	I	
	ROVIDER OR SUPPLIER		6701 S ANTHONY BLVD				
LUTHER	AN LIFE VILLAGES	S		FORT V	VAYNE, IN 46816		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
	ALGOLINGAL GA	250 132.(111 111.(0 11.11 011.1111101.()		1110			3.112
	Census payor type	e:					
	Medicare: 13						
	Medicaid: 91						
	Other: 67						
	Total: 171						
	Sample: 6						
	These deficiencies	s reflect state					
	findings cited in a	ccordance with 410					
	IAC 16.2.						
		npleted December 21,					
	2012 by Randy Fry	RN.					
	i				i		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LGSC11

Facility ID: 000283

If continuation sheet

Page 2 of 18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  IDENTIFICATION NUMBER: 155586  NAME OF PROVIDER OR SUPPLIER  LUTHERAN LIFE VILLAGES			(X2) M A. BUI B. WIN	survey eted /2012			
					WAYNE, IN 46816		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
F0241 SS=D	in a manner and imaintains or enhadignity and respector her individuality.  Based on interreview the facily baths 2 days presidents review sample of 3. (Farmer)  Findings included 1. Resident #U 12-18-2012 at #U's diagnoses limited to, demoressure, and a pressure, and a pressure, and a pressure and diagnoses sitting in her rook Resident #U was dressed and diagnoses and diagnoses are included by Unitable 12-18-2012 at Resident #U was dressed and diagnoses are included by Unitable 12-18-2012 at Resident #U was diagnoses and diagnoses are included by Unitable 12-18-2012 at Resident #U was diagnoses are included by Unitable 12-18-2012 at Resident #U was diagnoses and diagnoses are included by Unitable 12-18-2012 at Resident #U was diagnoses and diagnoses are included by Unitable 12-18-2012 at Resident #U was diagnoses are included by Unitable 12-18-2012 at Resident #U was diagnoses are included by Unitable 12-18-2012 at Resident #U was diagnoses and diagnoses are included by Unitable 12-18-2012 at Resident #U was diagnoses are included by Unitable 12-18-2012 at Resident #U was diagnoses are included by Unitable 12-18-2012 at Resident #U was diagnoses are included by Unitable 12-18-2012 at Resident #U was diagnoses are included by Unitable 12-18-2012 at Resident #U was diagnoses are included by Unitable 12-18-2012 at Resident #U was diagnoses are included by Unitable 12-18-2012 at Resident #U was diagnoses are included by Unitable 12-18-2012 at Resident #U was diagnoses are included by Unitable 12-18-2012 at Resident #U was diagnoses are included by Unitable 12-18-2012 at Resident #U was diagnoses are included by Unitable 12-18-2012 at Resident #U was diagnoses are included by Unitable 12-18-2012 at Resident #U was diagnoses are included by Unitable 12-18-2012 at Resident #U was diagnoses are included by Unitable 12-18-2012 at Resident #U was diagnoses are included by Unitable 12-18-2012 at Resident #U was diagnoses are included by Unitable 12-18-2012 at Resident #U was diagnoses are included by Unitable 12-18-2012	promote care for residents in an environment that ances each resident's ct in full recognition of his y.  Tview and record ity failed to provide er week for 2 of 3 wed for bathing in a Resident #U, Resident  Te:  The record was reviewed 3:47 PM. Resident included, but were not entia, high blood	F02	41	1. What measures were take for residents directly affecte  Shower routines for residents and #W were reviewed. No revisions were required to the current schedules. Facility revidemonstrates compliance with the regulation despite issuand this deficiency.  2. What measures were put place to identify other residents at risk?  All residents are at risk from the deficient practice. A complete facility audit of shower/bathing documentation was completed.  3. What systemic change was put in place to ensure the deficient practice does not recur?  Facility protocol regarding showers/bathing was reviewe with no revisions required.  A complete audit of all neighborhood shower records was completed 12-21-2012. Shower books are organized insure each resident has an identified schedule and	#U  view n ce of  in  d d	01/07/2013

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LGSC11

Facility ID: 000283

If continuation sheet

Page 3 of 18

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPLETED	
		155586	B. WIN			12/21/2012	
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	8					
LUTUED	ANT 155 VIII AOS				ANTHONY BLVD		
LUTHER	AN LIFE VILLAGES			FORT	WAYNE, IN 46816		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	evenings.				appropriate forms present for		
					documentation.		
	A review of AD	L (Activities of Daily					
		entation indicated			·Nursing staff have been		
	· •	eceived a bath or			in-serviced on the current		
					protocol, specifically related to bathing/shower regulations an		
		2-2012 (a Sunday) at 2			documentation.	u	
	· ·	012 (a Wednesday) at			documentation.		
	6 PM, and on 1	12-15-2012 (a			4. How will the corrective		
	Saturday) at 8	PM. There was no			action be monitored?		
	documentation	Resident #U had			Nursing Managers/shift		
	refused a show	ver or bath.			supervisor will perform daily		
					audits of showers based on ea	nch	
	2. Resident #W	l's record was			neighborhood's shower sched	ule	
					to insure completion as well as		
		3-2012 at 8:10 PM.			verify appropriate documentati	on.	
		diagnoses included,					
	but were not lir	nited to, dementia,			The Director of Nursing or		
	high blood pres	ssure and			designee will audit results on a		
	osteoarthritis.				daily basis for 8 weeks and on weekly basis for 12 weeks.	a	
					A monthly report of findings wi		
	During initial to	our on 12-18-2012 at			be submitted to the Quality	"	
		dent #W was observed			Assurance Committee, which		
					meets monthly, for the duration	n of	
		sident lounge in a			the audits prescribed above.		
	wheelchair. Re				Should the committee feel that	t	
	appropriately d	ressed and did not			systemic compliance is not be	ing	
	have a body or	dor.			achieved then audits will		
					continue, with possible additio		
	A review of CN	IA assignment sheet			corrective action, until complia	nce	
		nit Manager #2 on			has been achieved.		
	'	3:00 PM indicated no					
	_	for Resident #W's					
	shower or bath	l.					
		on 12-18-2012 at 3					
	PM, Unit Mana	ger #2 indicated the					
		evaluating the best					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LGSC11

Facility ID: 000283

If continuation sheet Page 4 of 18

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPL	ETED
		155586	B. WIN			12/21/	2012
		<u> </u>	b. Wilv		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	R			ANTHONY BLVD		
LLITHER	AN LIFE VILLAGES	3			VAYNE, IN 46816		
LOTTILIX		_		TORTY	VATINE, IIV 40010		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	time for Reside	ent #W's bath or					
	shower to more	e appropriately fit into					
	his time sched	ule. Unit Manager #2					
	further indicate	ed Resident #W had					
	been on his un	nit approximately 3					
	weeks.						
	A review of AD	L documentation					
		dent #W received a					
		r on 12-2-2012 at 2:44					
		012 at 6:08 PM, on					
12-11-2012 at 11 AM and at 2:13 PM,							
	and 12-12-201	2 at 3:55 PM.					
		on 12-19-2012 at					
	10:07 AM, Unit	t Manager #2 indicated					
	baths were bei	ing given at random					
	times maybe d	lue to a response to a					
	behavior.	•					
	A review of hel	havior logs indicated on					
		-11, and 12-12-2012 no					
	behaviors were						
	Deliaviole Well	a Hoteu.					
	In on interniero	on 10 10 0010 at 0:10					
		on 12-18-2012 at 3:46					
		ndicated sometimes					
	there were less						
		evening shift, and so					
	baths or showe	ers were not given to					
	the residents.	CNA #1 further					
	indicated the s	taff completed good					
		the residents would					
	l <sup>-</sup>	odor. CNA #1 also					
	1	ents should receive 2					
	baths or showe	cio pei week.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LGSC11

Facility ID: 000283

If continuation sheet Page 5 of 18

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/08/2013 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155586	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 12/21/2012
NAME OF F	PROVIDER OR SUPPLIEI	₹		ADDRESS, CITY, STATE, ZIP CODE ANTHONY BLVD	
LUTHER	AN LIFE VILLAGES	3		WAYNE, IN 46816	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	This Federal ta	ag relates to complaint 20765.			
	3.1-3(t)				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LGSC11

Facility ID: 000283

If continuation sheet

Page 6 of 18

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPL	ETED
		155586	B. WING		12/21/	2012	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
LUTUED	ANT IEE VIII ACEC				ANTHONY BLVD		
LUTHER	AN LIFE VILLAGES			FURI	WAYNE, IN 46816		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	_	DATE
PREFIX	REGULATORY OR  483.15(g)(1) PROVISION OF ITS SOCIAL SERVICE The facility must provide social services to highest practicable psychosocial wells.  Based on intervithe facility faile 2 of 3 residents behaviors in a state of the facility faile 2 of 3 residents behaviors in a state of the facility faile 2 of 3 residents behaviors in a state of the facility faile 2 of 3 residents behaviors in a state of the facility faile 2 of 3 residents behaviors in a state of the facility faile 2 of 3 residents behaviors in a state of the facility faile 2 of 3 residents behaviors in a state of the facility of the faci	MEDICALLY RELATED E provide medically-related attain or maintain the le physical, mental, and rebeing of each resident.  Wiew and record review do to track behaviors for some reviewed with sample of 3. (Resident W)  We record was reviewed 8:10 PM. Resident sincluded, but were dementia with urbances,	F02	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT	n d? d as cy.	COMPLETION
	the unit and tak solitude. The c	ke to quiet area for are plan did not ed for 1:1 or 15 minute			Nursing and social services staff have been in-serviced on current protocol, specifically related to appropriate		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LGSC11

Facility ID: 000283

If continuation sheet

Page 7 of 18

PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  A care plan titled Antipsychotic medication use dated 12-05-2012 did not indicate the reason for the medication, but included interventions of encourage to vent feelings, explore reasons for anxiety, give medications  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG  COMPLET DEFICIENCY  DATE  COMPLET DEFICIENCY  A. How will the corrective action be monitored? Social workers will perform daily audits of behaviors to verify appropriate documentation. The Director of Social Services or designee will audit compliance on a weekly	STATEMENT OF DEFI	i '	f í	MULTIPLE CON	NSTRUCTION	(X3) DATE SU	
NAME OF PROVIDER OR SUPPLIER  LUTHERAN LIFE VILLAGES  (X4) ID PREFIX TAG  A care plan titled Antipsychotic medication use dated 12-05-2012 did not indicate the reason for the medication, but included interventions of encourage to vent feelings, explore reasons for anxiety, give medications  STREET ADDRESS, CITY, STATE, ZIP CODE 6701 S ANTHONY BLVD FORT WAYNE, IN 46816  (X5) PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  A care plan titled Antipsychotic medication use dated 12-05-2012 did not indicate the reason for the medication, but included interventions of behaviors to verify appropriate documentation. The Director of Social Services or designee will audit sempliance on a workly will be corrective action be monitored? Social workers will perform daily audits of behaviors to verify appropriate documentation. The Director of Social Services or designee will audit sempliance on a workly were supposed to the provider of social Services or designee will audit sempliance on a workly were supposed to the provider of social Services or designee will audit sempliance on a workly were supposed to the provider of social Services or designee will audit sempliance on a workly were supposed to the provider of social Services or designee will audit sempliance on a workly were supposed to the provider of social services or designee will audit sempliance on a workly were supposed to the provider of social services or designee will audit sempliance on a workly were supposed to the provider of social services or designee will audit sempliance on a workly were supposed to the provider of social services or designee will audit sempliance on a workly were supposed to the provider of social services or designee will audit sempliance on a workly were supposed to the provider of social services or designee.	AND PLAN OF CORRE	N OF CORRECTION IDENTIFICA	ATION NUMBER: A. BU	UILDING	00		
LUTHERAN LIFE VILLAGES  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  A care plan titled Antipsychotic medication use dated 12-05-2012 did not indicate the reason for the medication, but included interventions of encourage to vent feelings, explore reasons for anxiety, give medications  (X5)  PREFIX (EACH DEFICIENCY) MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  A care plan titled Antipsychotic medication use dated 12-05-2012 did not indicate the reason for the medication, but included interventions of encourage to vent feelings, explore reasons for anxiety, give medications  (X5)  PREFIX (EACH DEFICIENCY) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE  (A care plan titled Antipsychotic medication of behaviors and related interventions.  4. How will the corrective action be monitored? Social workers will perform daily audits of behaviors to verify appropriate documentation. The Director of Social Services or designee will audit compliance on a weakly.		155586				12/21/2	012
LUTHERAN LIFE VILLAGES  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  A care plan titled Antipsychotic medication use dated 12-05-2012 did not indicate the reason for the medication, but included interventions of encourage to vent feelings, explore reasons for anxiety, give medications  (X5)  ID PROVIDER'S PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY)  A care plan titled Antipsychotic medication use dated 12-05-2012 did not indicate the reason for the medication, but included interventions of behaviors to verify appropriate documentation. The Director of Social Services or designee will and the completions of an analysis of part of the social Services or designee will and the completions of an analysis of part of the social Services or designee will and the completions of an analysis of part of the social Services or designee will and the completions of the social Services or designee will and the completions of the social Services or designee will and the completions of the social Services or designee will and the completions of the social Services or designee will and the completions of the social Services or designee will and the completions of the social Services or designee will and the completions of the social Services or designee will and the completions of the social Services or designee will and the completions of the social Services or designee will and the completion of the social Services or designee will and the completion of the social Services or designee will and the completion of the social Services or designee will and the completion of the social Services or designee will and the completion of the services of the social Services or designee will an anticological services or designee will an action of the services of the serv	NAME OF BROUNDER	E DE CAMBEE OF CAMBULEE	•	STREET AI	DDRESS, CITY, STATE, ZIP CODE		
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  A care plan titled Antipsychotic medication use dated 12-05-2012 did not indicate the reason for the medication, but included interventions of encourage to vent feelings, explore reasons for anxiety, give medications  (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (COMPLETE TO THE APPROPRIATE DEFICIENCY)  (ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY TO THE APPROPRIATE DEF	NAME OF PROVIDER	F PKOVIDEK OK SUPPLIEK		6701 S A	ANTHONY BLVD		l
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  A care plan titled Antipsychotic medication use dated 12-05-2012 did not indicate the reason for the medication, but included interventions of encourage to vent feelings, explore reasons for anxiety, give medications  (EACH DEFICIENCY)  PREFIX TAG  PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  documentation of behaviors and related interventions.  4. How will the corrective action be monitored? Social workers will perform daily audits of behaviors to verify appropriate documentation. The Director of Social Services or designee will audit compliance on a weekly.		RAN LIFE VILLAGES		FORT W	/AYNE, IN 46816		
A care plan titled Antipsychotic medication use dated 12-05-2012 did not indicate the reason for the medication, but included interventions of encourage to vent feelings, explore reasons for anxiety, give medications  TAG  CROSS-REFERENCED TO THE APPROPRIATE DATE  documentation of behaviors and related interventions.  4. How will the corrective action be monitored? Social workers will perform daily audits of behaviors to verify appropriate documentation. The Director of Social Services or designee will audit compliance on a weekly.					PROVIDER'S PLAN OF CORRECTION		(X5)
A care plan titled Antipsychotic medication use dated 12-05-2012 did not indicate the reason for the medication, but included interventions of encourage to vent feelings, explore reasons for anxiety, give medications  documentation of behaviors and related interventions.  4. How will the corrective action be monitored? Social workers will perform daily audits of behaviors to verify appropriate documentation. The Director of Social Services or designee will audit compliance on a weekly	,	, and the second			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
A care plan titled Antipsychotic medication use dated 12-05-2012 did not indicate the reason for the medication, but included interventions of encourage to vent feelings, explore reasons for anxiety, give medications  related interventions.  4. How will the corrective action be monitored? Social workers will perform daily audits of behaviors to verify appropriate documentation. The Director of Social Services or designee will audit compliance on a weekly	TAG REGI	REGULATORY OR LSC IDENT:	IFYING INFORMATION)	TAG			DATE
as ordered, monitor behaviors daily, monitor for side effects of medications, monitor mood and response to medication, Notify family and MD of any changes, provide calm environment. The care plan did not indicate the need for 1:1 or 15 minute checks.  There were no other care plans outlining behavior.  A review of behavior logs for 12-2012 indicated there were no behaviors between 12-1 and 12-15-2012.  A review of timed checks revealed on 12-1-2012 staff were with Resident #W consistently between 5:45 AM and 6 PM; on 12-6-2012 between 6 AM and 6:30 PM; on 12-12-2012 between 12 midnight and 2 AM, a note on the timed checks indicated Resident #W was on 1:1 observation; and on 12-13-2012 between 10:30 PM and 6:30 AM,	A care medic not in medic of end reaso as ord monit medic responsible and Menviro indicated between the continuation of end of end reaso as ord monit medic responsible and Menviro indicated between the continuation of end of e	A care plan titled Antiper medication use dated 1 not indicate the reason medication, but include of encourage to vent for reasons for anxiety, gives as ordered, monitor be monitor for side effects medications, monitor monitor for side effects medicated the need for 1: checks.  There were no other care indicated there were no other care indicated there were no other than 12-12-12-12-12 staff were work which were sidentally between 12-1-2012 staff were work which were sidentally between 3 PM and 10: 12-12-2012 between 12-12-12-2012 between 12-12-12-12-12-12-12-12-12-12-12-12-12-1	sychotic 12-05-2012 did for the ed interventions relings, explore we medications haviors daily, of nood and n, Notify family s, provide calm plan did not 1 or 15 minute  are plans  gs for 12-2012 behaviors 15-2012.  ks revealed on rith Resident en 5:45 AM 2 between 6 1-4 between 9 6-2012 30 PM; on 2 midnight and ned checks was on 1:1 1-13-2012	IAG	documentation of behaviors ar related interventions.  4. How will the corrective action be monitored? Social workers will perform daily audit of behaviors to verify appropria documentation. The Director of Social Services or designee with audit compliance on a weekly basis for 12 weeks, and month for three months. A monthly report findings will be submitted to Quality Assurance Committee, which meets monthly, for the duration of the audits prescribe above. Should the committee feel that systemic compliance in not being achieved then audits will continue, with possible additional corrective action, un	ts ate of ill ally poort the	DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LGSC11

Facility ID: 000283

If continuation sheet Page 8 of 18

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріп	LDING	00	COMPL	ETED
		155586	B. WIN			12/21/	2012
		<u> </u>	D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	R			ANTHONY BLVD		
LUTHER	AN LIFE VILLAGES	3			VAYNE, IN 46816		
LOTTILIX		_			VATNE, IN 40010		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Resident #W w	vas on consistent					
	watch.						
	In an interview	on 12-19-2012 at					
	10:07 AM. Unit	t Manager #2 indicated					
		vas on consistent watch					
		f increased agitation.					
		i moreasea agitation.					
	Δ hehavior log	dated 12-15-2012					
		dent #W was shaking					
		•					
		and had an unpleasant					
	mood.						
	The summary						
	12-15-2012 inc	dicated Resident #W					
	had been yellir	ng at staff, shaking fist,					
	and easily ang	ered. The					
	documentation	further indicated staff					
	had tried talkin	g to Resident #W to					
	calm him.	9					
	Δ hehavior log	dated 12-16-2012					
	_						
		dent #W was hitting					
		elling and having a					
	temper tantrun	n.					
	The summary						
	12-16-2012 inc	dicated Resident #W					
	screamed and	yelled at staff, tried to					
	hit staff, and be	ecame more agitated					
	with staff even	after given activities,					
		ne note did not indicate					
		nes were effective.					
	What approach	ioo more encoure.					
	In an interview	on 12-19-2012 at 9:37					
	i iii aii iiilei view	011 12-13-2012 at 3.31					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LGSC11

Facility ID: 000283

If continuation sheet Page 9 of 18

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	ETED
		155586	B. WIN			12/21/	2012
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	R.			ANTHONY BLVD		
LUTHER	AN LIFE VILLAGES	8			VAYNE, IN 46816		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	IE.	DATE
	AM, SSD #4 in	dicated Resident #W					
	was on 1:1 obs	servation because he					
	was agitated a	nd likely to fall. SSD #4					
	further indicate	-					
		not documented					
		ng the times Resident					
	_	nsistent watch. SSD #4					
		ed behaviors were					
		y and behavior notes					
		before were reviewed					
	_	ntions were discussed					
		at shift change. New					
	•	e placed on the CNA					
		eet when the nurse					
	_						
	_	quested to do so. SSD					
		ursing should be					
	_	ehavior to validate the					
		stent observation as					
		oproaches are effective					
	to improve resi	dent care.					
	2 Resident #\/	's record was reviewed					
		10:59 AM. Resident					
	_	s included, but were not					
	,	entia with behavioral					
	disturbances, o	•					
	obstruction, an	u paranoia.					
	A care plan ##	ad notantial for					
	A care plan title	•					
	alteration in be						
		uded interventions of					
	be aware of pa	_					
		ods and behaviors,					
		ernal stimulants, and					
	antecedents of	the behaviors.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LGSC11

Facility ID: 000283

If continuation sheet Page 10 of 18

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155586			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 12/21/2012	
	PROVIDER OR SUPPLIER		B. WIN	STREET A 6701 S	ADDRESS, CITY, STATE, ZIP CODE ANTHONY BLVD VAYNE, IN 46816	<u>I</u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	A behavior log indicated Resid on 12-15-2012 scratching, bitti tantrums, and I The summary 12-15-2012 indicated was pulling partiallway, yelling snacks, but Reyell and have on indication or effective. Addit not indicate an behaviors.  In an interview 10:07 AM, Unit the behavior locategories the and some cate screaming, cur one pick. Unfor summary note, tell exactly what the resident.	dated 12-2012 dent #V had behaviors of cursing, screaming, ng, yelling, temper hitting and cursing.  notes dated dicated Resident #V nts down in the g at staff, staff provided esident #V continued to outbursts. There was f an approach that was cionally, the notes did tecedents of the  on 12-19-2012 at t Manager #2 indicated togs had several staff could pick from tegories such as rsing, and biting were rtunately without the there was no way to the truns the staff could pick from tegories such as the staff could pick from tegories such a					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LGSC11

Facility ID: 000283

If continuation sheet

Page 11 of 18

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/08/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155586	A. BUILDING  B. WING	00	COMPLETED 12/21/2012			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 6701 S ANTHONY BLVD FORT WAYNE, IN 46816					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LGSC11

Facility ID: 000283

If continuation sheet Page 12 of 18

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155586	B. WINC			12/21/	2012
NAME OF PROVIDER OR SUPPLIER  LUTHERAN LIFE VILLAGES			STREET ADDRESS, CITY, STATE, ZIP CODE 6701 S ANTHONY BLVD FORT WAYNE, IN 46816				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	I	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ΓF	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)	DATE	
F0353 SS=E	483.30(a) SUFFICIENT 24-CARE PLANS The facility must be to provide nursing attain or maintain physical, mental, well-being of each by resident assest plans of care.  The facility must provide nursing caccordance with rescondance with rescondanc	HR NURSING STAFF PER  have sufficient nursing staff g and related services to the highest practicable and psychosocial h resident, as determined sments and individual  provide services by s of each of the following el on a 24-hour basis to are to all residents in resident care plans:  wed under paragraph (c) of sed nurses and other el.  wed under paragraph (c) of sed nurses and other el.  wed under paragraph (c) of sed intresident a serve as a charge nurse uty.  ervation, interview and the facility failed to the facility failed to the facility failed to the facility. This had the the fact all residents Magnolia unit.  de:  record was reviewed 8:10 PM. Resident s included, but were dementia, high blood	F035		1. What measures were taken for residents directly affected.  Shower routines for residents and #W were reviewed. No revisions were required to the current schedules. Facility revidemonstrates compliance with the regulation despite issuance this deficiency. Furthermore, the facility was not given the opportunity to discuss or defer this citation during the survey process. Lutheran Life Villages makes every effort to deploy stoased on the acuity and censur of each unit. The unit cited new	#U few le of he nd staff us	01/07/2013
	-				or each unit. The unit cited fiet	/CI	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LGSC11

Facility ID: 000283

If continuation sheet

Page 13 of 18

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SUF	RVEY
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPLETI	ED
155586		A. BUII B. WIN			12/21/20	12	
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER							
LUTUEDANLIEE VIII ACEC			6701 S ANTHONY BLVD FORT WAYNE, IN 46816				
LUTHERAN LIFE VILLAGES				FORT	WATNE, IN 40010		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE C	OMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					had a nursing staff to resident		
	During initial to	our on 12-18-2012 at			ratio of less than 1:10 during t		
	9:06 AM, Resi	dent #W was observed			period surveyed, with day and		
	I	esident lounge in a			evening nursing staffing at 1:7 plus a full time activity director		
	_	esident #W was			and ancillary staff.		
		dressed and did not			and unomary stant.		
	have a body o				2. What measures were put	in	
	l nave a body o	dor.			place to identify other		
					residents at risk?		
		NA assignment sheet			All residents are at risk from the	nis	
	provided by Ur	nit Manager #2 on			deficient practice. A complete		
	12-18-2012 at	3:00 PM indicated no			facility audit of shower/bathing		
	assigned time	for Resident #W's			documentation was completed	d.	
	shower or bath						
					3. What systemic change wa	as	
	In an interview	on 12-18-2012 at 3			put in place to ensure the		
					deficient practice does not		
		ager #2 indicated the			recur?		
		I evaluating the best			·Facility protocol regarding		
		ent #W's bath or			showers/bathing was reviewe	d	
	shower to mor	e appropriately fit into			with no revisions required.		
	his time sched	ule. Unit Manager #2					
	further indicate	ed Resident #W had			·A complete audit of all		
	been on his ur	nit approximately 3			neighborhood shower records		
	weeks.				was completed 12-21-2012.		
	1.00				Shower books are organized	to	
	A review of AF	OL documentation			insure each resident has an		
					identified schedule and		
		dent #W received a			appropriate forms present for documentation.		
		r on 12-2-2012 at 2:44			documentation.		
		012 at 6:08 PM, on			·Nursing staff have been		
	12-11-2012 at	11 AM and at 2:13 PM,			in-serviced on the current		
	and 12-12-201	2 at 3:55 PM.			protocol, specifically related to		
					bathing/shower regulations ar		
	In an interview	on 12-19-2012 at			documentation.		
		t Manager #2 indicated			·The nurse manager or		
		_			designee is responsible for		
		ing given at random			assisting the unit during unus	ual	
times maybe due to a response to a				times of heightened need.			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE							
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPLETED			
155586		155586	B. WIN			12/21/2012			
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE				
NAME OF PROVIDER OR SUPPLIER									
LUTUEDANLIEE VIII LACES				6701 S ANTHONY BLVD FORT WAYNE, IN 46816					
LUTHERAN LIFE VILLAGES				FURIV	WATINE, IN 400 10				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLE	ΓΙΟN		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)	DATE	ì		
	behavior.				4. How will the corrective				
					action be monitored?				
	A review of hel	havior logs indicated on			Nursing Managers/shift				
		-11, and 12-12-2012 no			supervisor will perform daily				
					audits of showers based on ea				
	behaviors were	e notea.			neighborhood's shower sched				
					to insure completion as well as				
	In an interview	on 12-18-2012 at 3:46			verify appropriate documentat	On.			
	PM, CNA #1 in	idicated sometimes			The Director of Nursing or				
	there were less	s than 2 CNAs			designee will audit results on a				
	scheduled on e	evening shift, and so			daily basis for 8 weeks and on				
	baths or showers were not given to the residents. CNA #1 further				weekly basis for 12 weeks.				
					A monthly report of findings wi	ı			
					be submitted to the Quality				
		taff completed good			Assurance Committee, which				
	partial baths so the residents would				meets monthly, for the duratio	n of			
	not have body	odor. CNA #1 also			the audits prescribed above.				
	indicated resid	ents should receive 2			Should the committee feel that				
	baths or showe	ers per week.			systemic compliance is not be	ng			
		•			achieved then audits will				
	Δ review of tim	ed checks revealed on			continue, with possible additio				
		f were with Resident			corrective action, until complia has been achieved.	rice			
					l lias been achieved.				
		y between 5:45 AM							
	l '	12-2-2012 between 6							
	AM and 6:30 F	PM;on 12-4 between 9							
	PM and 11 PM	l; on 12-6-2012							
	between 3 PM	and 10:30 PM; on							
		tween 12 midnight and							
		n the timed checks							
	·	dent #W was on 1:1							
	observation; and on 12-13-2012 between 10:30 PM and 6:30 AM, Resident #W was on consistent watch.								
	Resident #U's	record was reviewed							
		3:47 PM. Resident							
	12-10-2012 al	J.TI FIVI. INCOIDEIIL							

i '		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
		IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL		
155586		B. WIN	IG		12/21/	2012		
NAME OF F	PROVIDER OR SUPPLIEI	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE			
				6701 S	ANTHONY BLVD			
LUTHERAN LIFE VILLAGES			FORT WAYNE, IN 46816					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG				TAG	DEFICIENCY)		DATE	
	#U's diagnoses included, but were not limited to, dementia, high blood pressure, and arthritis.							
	. •	our on 12-18-2012 at						
	· ·	dent #U was observed						
	. •	oom in a wheelchair.						
		as appropriately						
	dressed and did not have a body odor.  A review of a CNA assignment sheet provided by Unit Manager #2 on 12-18-2012 at 3:00 PM indicated Resident #U was to receive a shower or bath on Wednesday and Saturday evenings.							
	A roughly of AF	L documentation						
	indicated Resident #U received a bath or shower on 12-2-2012 (a							
		•						
	Sunday) at 2 AM, on 12-5-2012 (a Wednesday) at 6 PM, and on							
	l • ·							
	12-15-2012 (a Saturday) at 8 PM. There was no documentation							
		ad refused a shower or						
		au reiuseu a silowei oi						
	bath.							
	Δ review of as	worked staffing						
		e Director of Nursing on						
		10 AM indicated 2						
		the unit 12-1-2012 from						
		1 ; on 12-2-2012, 2						
		signed the unit						
	petween 6 AM	and 6:30 PM; on						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LGSC11

Facility ID: 000283

If continuation sheet

Page 16 of 18

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING (COMPLETED 12/21/2012)				ETED		
		155586	B. WIN			12/21/	2012	
NAME OF PROVIDER OR SUPPLIER  LUTHERAN LIFE VILLAGES				STREET ADDRESS, CITY, STATE, ZIP CODE 6701 S ANTHONY BLVD FORT WAYNE, IN 46816				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
IAU	12-4-2012, 2 Cobetween 9 and 1 CNA was assimidnight and 1 12-13-2012 on between 10:30 A current CNA provided by Ur 12-19-2012 at residents need assist with their needed two petheir care.  In an interview 10:07 AM, Unit no one special consistent observation, of from another urand toileting. No help complete  In an interview PM, CNA #5 in rarely came to during busy time unit were experienced.	cNAs were assigned 11 AM; on 12-6-2012, signed between 12 AM, and on e CNA worked PM and 6 AM.  assignment sheet hit Manager #2 on 8:28 AM indicated 8 led at least 1 person to r care and 1 person ersons to assist with  on 12-19-2012 at the Manager #2 indicated is assigned for ervations or 1:1 ring times of consistent ther staff is brought nit to assist with care lurses also step up to tasks.  on 12-19-2012 at 2:07 indicated other staff the unit to assist mes. The staff on the cted to absorb the get things done.		IAU			DATE	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LGSC11

Facility ID: 000283

If continuation sheet

Page 17 of 18

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/08/2013 FORM APPROVED OMB NO. 0938-0391

I 155506		A. BUILDING B. WING				ETED		
NAME OF PROVIDER OR SUPPLIER  LUTHERAN LIFE VILLAGES			STREET ADDRESS, CITY, STATE, ZIP CODE 6701 S ANTHONY BLVD FORT WAYNE, IN 46816					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
	3.1-17(b)							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LGSC11

Facility ID: 000283

If continuation sheet Page 18 of 18